THE CRISIS FACING AMERICAN WOMEN: POLICY SOLUTIONS TO ADDRESS MATERNAL MORTALITY IN THE UNITED STATES

by
Lienna Feleke-Eshete

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Abstract

In July of 2018, an investigation by USA Today found that the United States is the most dangerous place to give birth in the developed world with 50,000 mothers severely injured during or after childbirth and 700 deaths, most of which are preventable. This crisis is further exacerbated among certain populations, including Black women, Native American women, women of lower income and older women. Throughout history, the United States has been a vocal advocate in the movement to improve maternal health outcomes globally, but this effort has not been reflected within U.S. borders. In 2018, Congress passed the *Preventing Maternal Deaths Act of 2018*, one of the first pieces of legislation to address this crisis in decades, which established a federally funded program to review pregnancy-related deaths and develop a solution. However, a review board is not enough; countless advocacy organizations and medical professionals have proposed policy solutions to address the underlying issue- a lack of access to affordable, convenient, unbiased and respectful maternity care for all women during the prenatal and postnatal periods. This capstone will explore innovative and inclusive federal policies to address the crisis plaguing women and families in the United States.

Advisor: Dr. Paul Weinstein

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TO: The Honorable Eleanor Holmes Norton,

Congresswoman of the District of Columbia

FROM: Lienna Feleke-Eshete

SUBJECT: Addressing Maternal Mortality Rate in the United States

DATE: May 7, 2019

I. Action Forcing Event

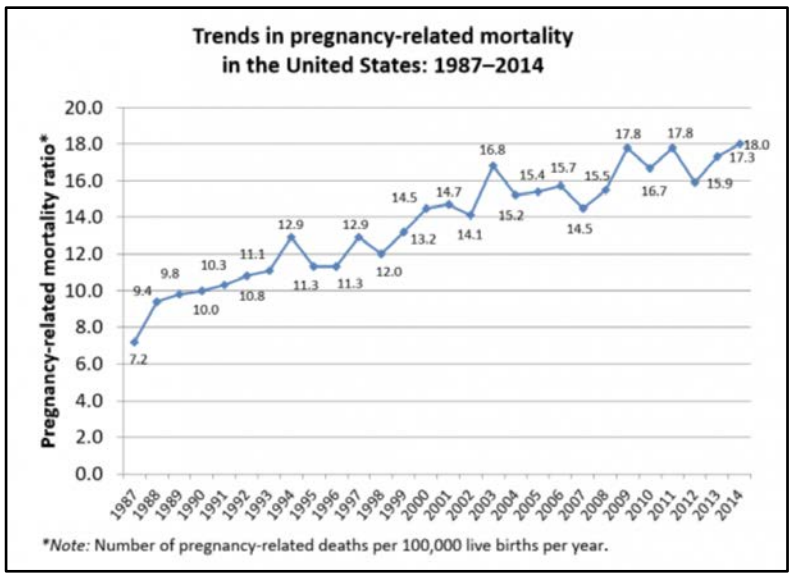
In July of 2018, an investigation by USA Today found that the United States is the most dangerous place to give birth in the developed world with 50,000 mothers severely injured during or after childbirth and 700 deaths, over half of which are preventable[1]. This issue was further shot into the spotlight when celebrity athlete, Serena Williams, shared her negative experience during childbirth with the public. In 2018, the outcry through the public health sector prompted Congress to pass the *Preventing Maternal Deaths Act of 2018* which establishes a federally funded program to review pregnancy-related deaths and provide policy recommendations to address the issue.

[1] Alison Young, "Deadly Deliveries," *USA Today*, July 26, 2018, https://www.usatoday.com/in-depth/news/investigations/deadly-deliveries/2018/07/26/maternal-mortality-rates-preeclampsia-postpartum-hemorrhage-safety/546889002/#iwasreallyscared

II. Statement of the Problem

The problem that this memorandum will address is the increasing maternal mortality rates in the United States, despite declining rates globally, due to a lack of access to high quality health care services. In 1986, the Center for Disease Control (CDC) began monitoring pregnancy-related deaths, defined as "the death of a woman while pregnant or within 1 year of the end of a pregnancy from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes"[2]. This data is provided by states and summarized by the CDC into an average pregnancy-related mortality ratio. This ratio is an estimate of the number of pregnancy related deaths for every 100,000 live births. The figure below shows the trends in the pregnancy-related mortality ratio since 1987. As depicted, in 1987 there were 7.2 pregnancy-related deaths for every 100,000 live births per year. This rate has increased continuously with an all-time high of 18 pregnancy-related deaths per 100,000 live births in 2015. In 2018, this number increased to 20 pregnancy-related deaths per 100,000 live births.

[2]Centers for Disease Control and Prevention, "Pregnancy Mortality Surveillance System," *CDC*, August 7, 2018, https://www.cdc.gov/reproductivehealth/maternalinfanthealth/pregnancy-mortality-surveillance-system.htm#when



As with many public health issues, maternal mortality disproportionately affects populations based upon their race, geography and age. The aforementioned statistics are averages of the mortality rates which vary largely among groups. In 2018, the number of deaths per 100,000 live births for Black women and American Indian women skyrocketed to 47.2 and 38.8, respectively, over double the rate for White women[3]. The severity of this issue also varies among age groups; women ages 25 to 34 have a rate of 14 while women ages 35 to 44 have a rate of 38.5 deaths per 100,000 live births. In the United States, some of the highest rates of maternal mortality occur in states like Louisiana and Georgia with over 40 deaths per 100,000 live births[4]. In the District of Columbia, a jurisdiction with a high Black population, the intersection of maternal mortality and race is particularly important. In D.C., 41 women die per 100,000 births

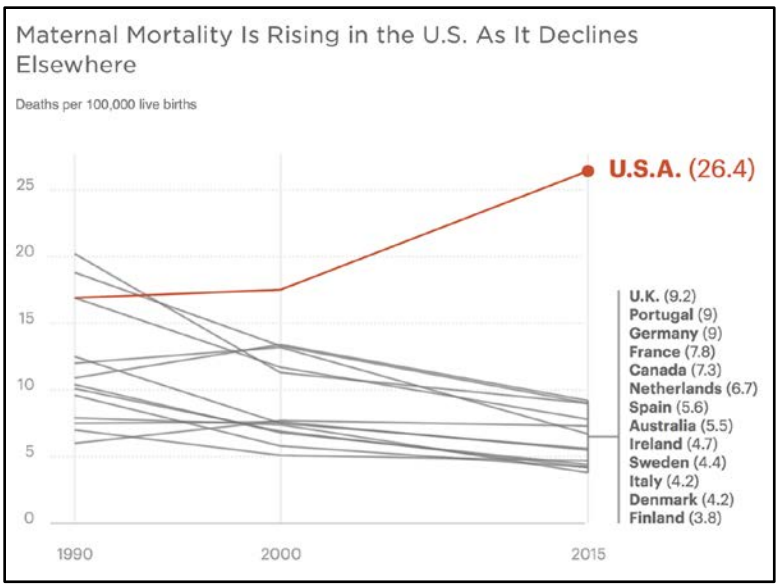
[3] America's Health Rankings, "Maternal Mortality in the United States in 2018," *United Health Foundation*, https://www.americashealthrankings.org/explore/health-of-women-and-children/measure/maternal_mortality

[4] Advisory Board, "The States with the highest (and lowest) maternal mortality, mapped," *Advisory Board*, November 9, 2018, https://www.advisory.com/daily-briefing/2018/11/09/maternal-mortality

and 75 percent of these deaths are among African American women[5]. Based on these numbers alone, it is clear that the United States is experiencing a maternal mortality crisis.

Despite its position as a global leader and advocate for public health, the United States falls far behind other developed nations in maternal health. In 2000, maternal mortality was incorporated as an aspect of the Millennium Development Goals (MDGs). The MDGs are human rights and public health goals that all countries agree to prioritize, including access to safe maternal healthcare as a human rights issue. Despite the United States' involvement in global improvements for maternal health, it has not yet achieved its own development goals and human rights obligations to American women. In 2015, the United States had a maternal mortality ratio that was almost three times that of the United Kingdom and almost seven times that of Finland. In 2015, the United States was ranked 46th in a comparison of global maternal mortality rates, below Saudi Arabia, Bulgaria, Libya and Kuwait. The rate for Black women in the United States in 2018 (47.2) is equivalent to the average maternal mortality rates in Palestine and Iraq.

[5] Editorial Board, "D.C.'s maternal mortality rate is at crisis proportions," *The Washington Post*, April 21, 2018, https://www.washingtonpost.com/opinions/dcs-maternal-mortality-rate-is-at-crisis-proportions/2018/04/21/cc268af2-4411-11e8-8569-26fda6b404c7_story.html?utm_term=.97cb8be555fb



The increase in maternal mortality rates is more than just a public health issue; it affects economics, demographics, human rights, and social stability. As stated by Miranda Klassen, a maternal health advocate, “The pain and suffering is exponential. It's not just the moms, it's the spouses, it's the parents, it's the children, it's the larger family and community.[6]" The widespread impact of maternal mortality on families and children has been studied internationally. Children whose mothers died during childbirth have an increased chance of mortality than children whose households did not experience a maternal death[7]. These same motherless children are more likely to be malnourished and less likely to pursue an education. Families that experience the death of a mother during childbirth are more likely to live in poverty, experience financial instability and suffer from mental illnesses, such as depression. All of the aforementioned correlations increase the detrimental impact of this issue. It is estimated that the medical care associated with

[6] Katherine Ellison, “Nearly Dying in Childbirth: Why Preventable Complications Are Growing in US,” *NPR*, December 22, 2017, https://www.npr.org/2017/12/22/572298802/nearly-dying-in-childbirth-why-preventable-complications-are-growing-in-u-s

[7] National Research Council (US) Committee on Population, “Evidence on the Consequences of Maternal mortality,” *National Academies Press (US)*, https://www.ncbi.nlm.nih.gov/books/NBK225436/

maternal mortality alone costs the United States 1 billion dollars annually. As the mortality rates continue to increase, so will the economic and socio-economic costs.

Though there are various underlying reasons for these increasing rates, including lack of safe abortion and family planning resources across the country, this policy memorandum will focus on one causal factor- a lack of access to convenient, quality, respectful healthcare for all American women.

III. History/Background

Maternal death has occurred throughout history, but it was initially not considered to be a public health issue. In the 1800's, expectant mothers were largely cared for by midwives, most of whom had mixed results and no standard practices. As the profession of medicine became more popular and lucrative, doctors began to consider participating in the child birthing process; however, they were provided with very little training by medical schools and no standard protocols for practices. Randi Hutter Epstein, a doctor and author, described the medical techniques used by doctors during this time period in his book *Get Me Out: A History of Childbirth from the Garden of Eden to the Sperm Bank*. In the 1800s, Epstein states that "babies stuck in the birth canal were dragged out by the doctor, often in pieces… Sometimes doctors broke the pubic bone, which often killed the mother but spared the baby. Doctors had an entire armamentarium of gruesome gadgets to hook, stab, and rip apart a hard-to-deliver baby. Many of these gadgets had an uncanny resemblance to medieval torture tools.[8]" Without medical protocols for childbirth, doctors utilized unnecessary and dangerous procedures, such as episiotomies, deep sedation and cesarean sections that often killed the mother due to blood loss or infection. 40 percent of maternal deaths during this period were attributed to sepsis, either after delivery or during illegally induced abortions. Irvine Loudon, a maternal health expert, stated "If I was forced to identify one factor above all others as the determinant of high maternal mortality in the USA [at the time], I would unhesitatingly choose the standard of obstetric training in the medical schools."

[8] Laura Helmuth, "The Disturbing, Shameful History of Childbirth Deaths," *Slate*, September 10, 2013, https://slate.com/technology/2013/09/death-in-childbirth-doctors-increased-maternal-mortality-in-the-20th-century-are-midwives-better.html

In addition to a lack of medical training on childbirth practices, doctors also lacked knowledge on how to prevent infection. Physicians would often attend to expectant mothers without disinfecting their hands or tools after procedures on sickly humans or even after autopsies. This spread infections through contact and many women in the early 1900's died after childbirth of puerperal fever, a uterine infection that can occur after childbirth. Half of maternal deaths in 1920 were attributed to puerperal fever. The detrimental effect of this lack of training was further proven by documented higher maternal death rates for wealthier women who gave birth at hospitals than maternal death rates of poorer women who could not afford hospitals and gave birth at home with midwives.

The high mortality rates continued until the 1930's when attention was called to this issue. A White House Conference on Child Health Protection, Fetal, Newborn and Maternal Mortality and Morbidity report issued in 1933 demonstrated the correlation between poor aseptic practice, overuse of operative deliveries and maternal mortality rates[9]. The results of this report prompted state medical associations to establish hospital and state maternal mortality review committees that institutionalized guidelines for practice and physician qualifications for hospital delivery privileges, neither of which previously existed. Medical advances during this period also introduced sulfa antibiotics which were effective against the bacteria that caused puerperal fever and stopped many preventable deaths. All of these factors contributed to a decrease in maternal mortality and by 1948, the mortality rate had decreased by 71 percent. The availability of Medicaid

[9] MMWR, "Weekly Report," *Mortality and Mortality Weekly Report*, *48*(38), pp. 853-854

and other federal programs further decreased this rate in the late 1960s; however, since 1982, maternal mortality rates have been stagnant[10].

Though population-wide maternal mortality rates decreased during the mid-19th century, they did not do so in an equitable manner across race and socioeconomic status. From 1935 to 1982, Black women maintained a mortality rate that was 3 to 4 times higher than that of white women; this disparity between White and Black women's mortality rates continues today[11]. Women living in poverty also had a 220 percent higher maternal mortality risk than other women in 1969-1971.

The History of Policy-

Initially, maternal mortality and maternal health were not considered seminal policy issues in the United States, as maternal deaths were seen as caused by unskilled doctors or insufficient hospitals instead of the result of a systematic public health problem. The impetus on developing maternal health policies in the United States came largely from goals set by international nongovernmental organizations, such as the United Nations and the World Health Organization. The international focus on this issue was provoked by a research study entitled *Maternal Health- A Neglected Tragedy: Where is the M in MCH (Maternal and Child Health)* which critiqued the lack of attention paid to maternal health and its correlation to child health, both in the United States and globally[12]. The paper stated that "in discussions of MCH it is commonly assumed that

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[10] MMWR, Weekly Report, *Mortality and Mortality Weekly Report*, *48*(38), pp. 849-858. https://www.cdc.gov/mmwr/preview/mmwrhtml/mm4838a2.htm

[11] Gopal K. Singh, "Maternal Mortality in the United States, 1935-2007: Substantial Racial/Ethnic, Socioeconomic, and Geographic Disparities Persist," *Health Resources and Services Administration, Maternal and Child Health Bureau*, https://www.hrsa.gov/sites/default/files/ourstories/mchb75th/mchb75maternalmortality.pdf

[12] Allan Rosenfield, "Maternal Mortality- A Neglected Tragedy: Where is the M in MCH?" *The Lancet*, July 13, 1985, https://www.unicef.org/devpro/files/A_Rosenfield_et_al_Maternal_Mortality_1985.pdf

whatever is good for the child is good for the mother. However, not only are the causes of maternal death quite different from those of child death but so are the potential remedies." The authors recommended that international organizations, such as UNICEF and the World Bank, make research into maternal health solutions and funding for maternal health policy a top priority. Shortly thereafter in 1987, maternal health became an established priority within the global health and development sectors. In 1987, the Safe Motherhood Initiative, one of the first nongovernmental organizations dedicated to maternal health, developed a policy approach to address this issue[13]. The four-pronged approach included "adequate primary health care and an adequate share of available food for females from infancy to adolescence, and universally available family planning; good prenatal care, including nutrition, with early detection and referral of those at high risk; the assistance of a trained person at all births; and access to the essential elements of obstetric care for women at higher risk." After the development of Safe Motherhood's approach, maternal health became a discussion point in the 1994 International Conference on Population and Development (ICPD) and the International Conference on Women in 1995. The ICPD conference resulted in the development of a Programme of Action that emphasized the importance of measuring progress on maternal health. In 2000, the United Nations established Millennium Development Goals (MDGs) which focused on a variety of issues, including improving public health, poverty, education access, gender equality and environmental sustainability in the new millennium[14]. These

[13] Tim Thomas,"Maternal Health from 1985-2013: Hopeful Progress and Enduring Challenges," *Catherine T. MacArthur Foundation*, December 2013, https://www.macfound.org/media/files/MHRetrospective_FINAL.pdf

[14] United Nations General Assembly, "United Nations Millennium Declaration", *United Nations*, September 18, 2000, http://www.un.org/en/ga/search/view_doc.asp?symbol=A/RES/55/2

goals were unique because they separated maternal health from child health. The Millennium Goals aspired to decrease maternal mortality ratios by 75 percent globally by 2015. The inclusion of maternal health and decreasing maternal mortality in the Millennium Development goals increased buy-in into this issue by policymakers and government leaders across the globe. Since 2000, many nongovernmental organizations have developed maternal health initiatives, conferences and campaigns that have even attracted the attention of private corporations, such as Johnson & Johnson and Merck.

Policymakers in the United States followed the international lead and began to develop initiatives to address maternal mortality. In 1986, the Centers for Disease Control and Prevention (CDC) established a Pregnancy-Related Mortality Surveillance System to monitor maternal deaths in the United States[15]. The data from this system is utilized to shed light on circumstances, causes and prevention of pregnancy-related deaths. The examination of the CDC data and public health records depicted five major medical causes of maternal mortality- embolism, hemorrhage, preeclampsia, infection, and cardiomyopathy[16]. Later, postpartum depression was incorporated as another widely accepted cause of maternal health decline, as it is often unrecognizable and when left untreated can lead to new mothers committing suicide. The likelihood of a mother encountering the aforementioned pregnancy complications is dependent upon a variety of social factors, including access to healthcare, health history, race, education and

[15] Centers for Disease Control and Prevention, "Pregnancy Mortality Surveillance System," *CDC*, August 7, 2018, https://www.cdc.gov/reproductivehealth/maternalinfanthealth/pregnancy-mortality-surveillance-system.htm#used

[16] Amnesty International, "Deadly Delivery: The Maternal Health Care Crisis in the USA," *Amnesty International*, May 7, 2011, https://www.amnestyusa.org/reports/deadly-delivery-the-maternal-health-care-crisis-in-the-usa/

socioeconomic status[17]. Women who do not have access to prenatal care, often women of lower socioeconomic status and/or women of color, are at a higher risk for maternal death. Additionally, women of lower income backgrounds encounter higher levels of pregnancy complications and maternal death due to elevated stress levels and stress-induced medical conditions such as obesity and high blood pressure.

Because maternal mortality rates vary across race, socioeconomic class and geography, it has been difficult to propose policies in the United States to address this crisis and the issue was largely ignored for decades. In 2016, the CDC and the Association of Maternal and Child Health Programs created an initiative entitled *Building U.S. Capacity to Review and prevent Maternal Deaths* to work with states to evaluate current mortality trends and propose policy solutions[18]. The first of these reports was issued in 2018 and in the same year, Congress passed bipartisan legislation entitled the Preventing Maternal Deaths Act of 2018 (H.R. 1318)[19]. The bill amends the Public Health Service Act, originally enacted in 1944 and housed under Title 42 of the US Code, by mandating the Department of Health and Human Services (DHHS) to create a $58 million grant program for states and Native American tribes to create maternal mortality review committees from 2019 to 2023. The data provided from these committees will be submitted to a national data collection program and reviewed by DHHS on an annual basis to examine trends in mortality and provide data for future policy solutions. The bill

[17] Quintanilla Ayala, A. Taft, S. McDonald S *et al,* "Social determinants and maternal exposure to intimate partner violence of obstetric patients with severe maternal mortality in the intensive care unit: a systematic review protocol," *BMJ Open,* 2016, https://www.ncbi.nlm.nih.gov/pubmed/27895065

[18] CDC Foundation, "Building US Capacity to Review and Prevent Maternal Deaths," *CDC Foundation*, https://www.cdcfoundation.org/building-us-capacity-review-and-prevent-maternal-deaths

[19] Congress.gov, "H.R. 1318- Preventing Maternal Deaths Act of 2018," *Congress.gov*, https://www.congress.gov/bill/115th-congress/house-bill/1318

incorporates specific requirements for these committees in order to ensure uniform and comprehensive data collection and accuracy of data. Each committee must include multidisciplinary and diverse membership, including clinical specialties, statisticians, community organizations and local health officials. Once the committee is composed, the members must demonstrate to the Centers for Disease Control and Prevention (CDC) that the methods and processes for data collection align with best practices and incorporate privacy protections and confidentiality of information. The Preventing Maternal Deaths Act of 2018 is one of the most significant actions by the U.S. government to address the maternal mortality crisis to date. Federal actions in the United States are also being supplemented by state and local policies to address more prevalent causes of maternal mortality on the local level. In March of 2018, Indiana passed Senate Bill 142 which establishes a statewide maternal mortality review committee to evaluate factors that are causing Indiana's high maternal mortality rate[20]. In Washington, D.C., Mayor Muriel Bowser hosted Washington, D.C.'s first Maternal and Infant Health Summit which brought public health experts and elected officials from across the country to discuss state policies to address the rising mortality rates, particularly among Black women[21].

Across the United States and globally, maternal health and decreasing maternal mortality has been a bipartisan public health issue since the 1980s. Many nongovernmental organizations, nonprofit organizations, governments, and public health experts have expressed the need to urgently address this issue to save women and girls

[20] N Martin, "Here's One Issue Blue and Red States Agree On: Preventing Deaths of Expecting and New Mothers," *ProPublica*, March 26, 2018, https://www.propublica.org/article/lost-mothers-series-impact-maternal-mortality-legislation

[21] Muriel Bowser, "Mayors from Across the Country to Join Mayor Bowser for DC's First Maternal and infant Health Summit," *The Office of Muriel Bowser, Mayor*, August 29, 2018, https://mayor.dc.gov/release/mayors-across-country-join-mayor-bowser-dc's-first-maternal-and-infant-health-summit

across the globe. Despite these efforts, maternal mortality rates in the United States are still comparatively high, particularly for a nation with advanced medical technology and a high GDP.

IV. Policy Proposal

The goal of this policy is to decrease preventable maternal deaths in the United States by 50 percent by 2030 by addressing the gaps in healthcare access for women in the United States. Given that the maternal mortality ratio globally has been decreased by 45 percent since 1990, this vision is attainable[22]. As the causes of maternal mortality are complex and affect certain populations differently, the solution to address this issue will be multi-pronged and nuanced. This policy proposal will address one of the largest causes of maternal mortality, a lack of access to convenient, affordable, equitable healthcare. The suggested policy solution will be implemented through legislative action with Congresswoman Holmes Norton as a co-sponsor of the bill and bipartisan Congressional support.

The policy, entitled the Respect Mothers' Care Act of 2019 ("RMCA"), combines a sticks and carrots approach to address this complex public health issue and incorporates previously proposed legislation and innovative approaches proposed by experts in the field of maternal health. The RMCA prompts states to address maternal mortality by providing $73,000,000 of funded mandates and grants to increase healthcare access. The bill would allocate funds through annual appropriations to the Department of Health & Human Services to state-level Health agencies for several purposes. The first purpose is to incentivize states to establish pregnancy medical home programs. These programs, currently implemented in North Carolina, provide pregnancy services for pregnant women who receive Medicaid and who are often disproportionately affected by

[22] L. Haddou, "Maternal mortality down 45% globally, but 33 women an hour are still dying," *The Guardian*, May 7, 2014, https://www.theguardian.com/news/datablog/2014/may/07/maternal-mortality-rate-drops-half-report-who-childbirth-pregnancy

the maternal mortality crisis[23]. The currently implemented pregnancy medical home programs in North Carolina incorporate a more patient-centered approach with financial incentives for patients, risk assessments, and community-specific guidance and materials for expectant mothers. The program incentivizes physician buy-in by providing financial incentives through Medicaid to doctors who perform risk screenings, provide care for vaginal deliveries and complete postpartum visits. By increasing accessibility of comprehensive care for women and incentivizing doctors to provide this care, pregnancy medical home programs aim to decrease maternal mortality while promoting healthy birth outcomes and respectful maternal care. Pregnancy medical home programs also collect data on participants which can be used for longitudinal studies on maternal mortality within states.

The second purpose of the RMCA is to require states to provide incentivized funding to local obstetric care providers to explore telehealth services and telehealth-associated training. The goal of this program is to provide community-specific solutions to address a lack of access to health care centers in rural areas that, ultimately, leads to unhealthy mothers and babies. The telehealth programs will utilize mobile health vehicles that are equipped with standard equipment used in prenatal, postnatal and obstetric appointments and will offer virtual appointments via video conference. This approach was originally introduced by Senator Heitkamp in the Rural MOMS Act of 2018.

Lastly, the RMCA will attempt to address the underlying racial causes of increasing maternal mortality by creating a grant program previously proposed by Senator Harris in the Maternal CARE Act of 2018. This grant would be awarded by the

[23] Community Care of North Carolina, "Pregnancy Medical Home," https://www.communitycarenc.org/what-we-do/clinical-programs/pregnancy-medical-home

Department of Health and Human Services to health professional training programs that address implicit bias in the practice of obstetrics and gynecology. By increasing awareness of biases that exist within the practice of medicine, physician training programs can promote harm-mitigation, cultural humility and awareness.

In order to ensure state government accountability and avoid misappropriation of funds, the RMCA will charge the Department of Health and Human Services with ensuring that funds are used as intended and set up an accountability measure through which community members, health care staff and others may report suspected misuse of funds. The implementation of the RMCA will begin in the next federal fiscal year. It is expected that states will receive mandate funding by October of 2020 and the local programs will commence in shortly thereafter.

V. Policy Analysis

The goal of the Respect Mothers' Care Act of 2019 is to decrease preventable maternal deaths that are caused by lack of access to healthcare. The proposed policy method- through Congressional legislation- allows increased buy-in by congressional leaders and state governments that will be creating the on-the-ground policies. The legislation will also ensure stability, as it cannot be repealed or altered without Congressional approval. Given the rapid passage and bipartisan support for the Preventing Maternal Deaths Act of 2018, this legislation may be passed without controversy, and the increasing public attention towards the maternal mortality crisis will place pressure on legislators to protect women in their districts. At the same time, the choice to introduce the policy through Congressional legislation is time consuming and provides an opportunity for the legislation to undergo extensive alteration in the legislative process.

The RMCA combines funded state mandates and grants to medical training programs to address healthcare inaccessibility that leads to worse maternal health outcomes. Overall, the cost benefit of the legislation is positive- for $73,000,000 of funding through this bill, the United States can decrease the $1 billion annually spent on maternal mortality associated health costs and decrease subsequent spending on social safety nets for families affected by maternal death[24]. The legislation can also contribute to local economies and productivity by extending life and preventing financial costs associated with early, preventable deaths of mothers.

[24] Katherine Ellison, "Nearly Dying in Childbirth: Why Preventable Complications are Growing in U.S," *NPR*, December 22, 2017, https://www.npr.org/2017/12/22/572298802/nearly-dying-in-childbirth-why-preventable-complications-are-growing-in-u-s

The policy focuses largely on funded mandates to allow states to customize their policies based on local need. This specialization encourages states to take action based on what is necessary for their constituencies and promotes diversification of approaches to policy development and implementation across the nation. In states with high variation in maternal mortality across race or socioeconomic class, proposed policies can incorporate specific efforts to mitigate harm to the disproportionately affected communities. At the same time, this characteristic of the RMCA relies upon states to commit to decreasing maternal deaths and invest time and resources into a program that aims to benefit some of the most historically disenfranchised communities. Depending on state government buy-in, the policies can range greatly in efficacy. The diversity of policies can also create difficulty in measuring the efficacy of the efforts. In order to address this, states should be required to utilize a standard measurement of maternal mortality to allow comparison across state programs and over time, such as the average pregnancy-related mortality ratio established by the CDC.

The first aspect of the proposed policy, a funded state mandate for pregnancy medical home programs, has been shown to have the potential to significantly decrease maternal deaths. This program has been used in North Carolina and similar programs have been implemented in other states to create incentives for pregnant women on Medicaid to keep up with their health checkups. These programs are often led by a committee or board of resident experts who provide guidance and, in the process, determine appropriate standards for care for participating health centers. This is useful as these standards create a uniformity of practice among physicians caring for expectant mothers pre and post childbirth that are based in respectful care and harm mitigation. In

North Carolina, since the inception of the pregnancy medical program in 2011, there has been a decrease of 6.7% in the rate of low birthweight babies among mothers on Medicaid[25]. This decrease in low birthweight babies has also saved the state money on costly newborn health care services that are required for underweight or premature babies. The North Carolina program has also led to a 17.6% reduction in inpatient spending, a decrease in ambulatory spending and 9% savings by the North Carolina Medicaid program[26]. It is estimated that for every $1 invested in the North Carolina program, over $3 in savings are generated, and the state expects to save close to $1 million in the first year and up to $9 million in the second[27]. If expanded nationally, these programs would be sustainable and self-sufficient, as the funding comes from Medicaid money saved by decreasing maternal mortality and improving infant health. By examining the impact of the programs in North Carolina, it is clear that pregnancy medical home programs have the potential to decrease maternal mortality, increase positive newborn health outcomes and save money. A drawback of the program is it has not been tested outside of North Carolina; it is unclear if the outcomes can be generalized to all states or if the program will still be cost efficient. It is likely that more research will be required to assure the efficacy of these programs across various geographic regions and to explore if states have the institutional capacity to adopt such programs within their healthcare networks. The program will also require buy-in from local physicians and the hiring of experts who can provide leadership and expertise to the program administrators.

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[25] K. Berrien, "Pregnancy Medical Home Care Pathways Improve Quality of Perinatal Care and Birth Outcomes," *North Carolina Medical Journal*, *76*(4), pp. 263-266

[26] NCIOM, "Understanding Community Care of North Carolina," http://nciom.org/wp-content/uploads/2018/04/CCNC-Primer-FINAL-4-26-18.pdf

[27] Zero to Three, "North Carolina Pregnancy Medical Homes," September 20, 2016, https://www.zerotothree.org/resources/866-north-carolina-pregnancy-medical-homes

The availability of these experts may vary across states. Finally, the largest drawback of this program is that it only provides the aforementioned services to Medicaid recipients. This excludes many other women who are disproportionately affected by maternal mortality and a lack of healthcare access, including middle or upper class women of color, who have been shown to have the same risk of maternal mortality as lower income women, or older women[28]. By catering this program to Medicaid recipients, the RMCA is excluding many women from receiving necessary assistance. To expand the reach of the RMCA, a similar pregnancy medical home program should be developed for members of racial, ethnic and socioeconomic groups that are known to suffer from maternal mortality at higher rates.

The second component of the RMCA incentivizes telehealth programs and telehealth training. Telehealth is a new technology that has the potential to transform the medical field and doctor-patient interactions. By providing mobile health units and online communication platforms, telehealth has the potential to expand healthcare access beyond the current patient base, particularly amongst minority groups and women living in rural areas. In a study conducted in a Miami minority community, clients of mobile health centers (MHCs) were more likely to keep up with prenatal care than other mothers[29]. Miami MHC patients also had lower rates of preterm and low-birth-weight infant births. Part of what makes telehealth and MHCs effective in reaching minority populations is the trusting relationships that they encourage. By providing healthcare

[28] Richard Reeves, "6 Charts Showing Race Gaps Within the American Middle Class," *Brookings*, October 21, 2016, https://www.brookings.edu/blog/social-mobility-memos/2016/10/21/6-charts-showing-race-gaps-within-the-american-middle-class/

[29] S. Yu, C. Hill, ML Ricks, *et al.*"The scope and impact of mobile health clinics in the United States: a literature review," *International journal for equity in health*, *16*(1), 178.

services to patients in their own communities, in a convenient location and in an informal setting, physicians can establish relationships with communities that are often neglected or hesitant to seek medical care[30]. Telehealth also offers a solution to the lack of accessibility of healthcare for many women in rural areas. A study in 2014 found that 54 percent of rural counties have no hospitals with obstetric services which results in fewer prenatal doctor's visits for expectant mothers and longer transportation times during labor[31]. It is estimated that the average doctor's visit costs a patient $43 just in lost time; this cost is even higher for rural women who have to travel long distances for checkups[32]. These same women often do not have flexible work schedules or have competing responsibilities that make it difficult for them to travel long distances for medical care in non-emergency circumstances. Telehealth is also cost efficient for physicians who can use online telemedicine platforms and virtual appointment technology for a multitude of purposes like billing and allows doctors to schedule shorter follow-up visits[33]. In a study conducted, it was found that a mobile health clinic saved over $20,000,000 annually compared to the mere cost of $567,000 to run the program, a 36:1 return on investment[34]. Lastly, telehealth and telemedicine allow more patient engagement and reinforce treatment adherence for patients with chronic conditions or expectant mothers.

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[30] Sara Heath, "How Do Mobile Health Clinics Impact Patient Access to Care?" *Patient Engagement HIT*, November 7, 2018, https://patientengagementhit.com/news/how-do-mobile-health-clinics-impact-patient-access-to-care

[31] Mackenzie Bean, "54% of rural counties do not have a hospital that offers obstetric care," *Becker's Hospital Review*, September 6, 2017, https://www.beckershospitalreview.com/patient-flow/54-of-rural-counties-do-not-have-a-hospital-that-offers-obstetric-care.html

[32] Brad Tuttle, "It Costs You $43 to Sit Around the Doctor's Waiting Room," *Money*, October 6, 2015, http://money.com/money/4063039/time-money-doctor-visit-healthcare/

[33] eVisit, "Pros and Cons of Telehealth for Doctors," *EVisit*, May 26, 2018, https://evisit.com/resources/pros-and-cons-telehealth-for-doctors/

[34] Nancy Oriol, "Calculating the return on investment of mobile healthcare," *BMC Medicine*, *7*(27), https://doi.org/10.1186/1741-7015-7-27

The largest drawback of telehealth services is the regulatory restrictions associated with this new technology[35]. There are varying laws across states regarding telehealth and often a lack of policy regarding issues like patient privacy protection or standards for telehealth care. Though the field of medicine seems ready to adopt telemedicine, policymakers are not yet. If a state has laws against mobile health units or traditionalistic regulations for physician visits, that state will be unable to adhere to the federal mandate and could face sanctions. Prior to the implementation of the RMCA, Congress needs to act to standardize telehealth regulations or motivate states to do so. Additionally, telehealth and mobile health services can lead to shortages of providers in health centers, particularly in areas with preexisting shortages of physicians[36].

The third component of the RMCA is a grant program to incentivize medical training programs to incorporate implicit bias trainings into their curriculum. It has been proven that implicit bias plays a large role in medical disparities among genders and races regardless of education or socioeconomic status[37]. Various factors, including race, education level, clothing, and manner of speaking have all been proven to influence the quality of medical care that many women of color receive[38]. Research has proven that often Black women's concerns are not taken as seriously. This results in fewer referrals for specialized care and fewer pain medication prescriptions for Black patients than for

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[35] Rita Marcoux & F. Randy Vogenberg, "Telehealth: Applications From a Legal and Regulatory Perspective," *P & T : a peer-reviewed journal for formulary management*, *41*(9), 567–570,
[36] N.M. Neke, G. Gadau, & J. Wasem, "Policy makers' perspective on the provision of maternal health services via mobile health clinics in Tanzania-Findings from key informant interviews," *PloS one*, *13*(9), e0203588, doi:10.1371/journal.pone.0203588
[37] Irene Blair, John Steiner, & Edward Havranek, "Unconscious (implicit) bias and health disparities: where do we go from here?" *The Permanente journal*, *15*(2), 71–78.
[38] Rebecca Grant, "Pregnant Women's Medical Care Too Often Affected by Race," *Newsweek*, July 3, 2016, https://www.newsweek.com/2016/07/15/pregnant-womens-care-affected-race-477087.html

White patients with the same complaints[39]. Many universities and medical training programs have already begun to incorporate implicit bias training and evaluation into their programs. It has been proven that implicit bias trainings do contribute to a decrease in implicit racial bias, even if incrementally. However, there is much concern over the efficacy of these programs. Because implicit bias programs are a new phenomenon, there is little research supporting their efficacy, few uniform standards of training and almost no metrics of evaluation[40]. As a result, the efficacy of programs can vary largely based on the administrator and the environment. If implemented in medical programs, implicit bias programs should incorporate formal trainings, informal trainings and interracial contact to be most impactful[41]. These programs should also be prolonged over a medical student's career to maximize impact. Though implicit bias programs vary largely, many of them begin with the administration of the Implicit Association Test, a self-administered test that shows participants their implicit biases. However, the accuracy of the methodology in this test has been called into question[42]. It is also possible that, once the test is administered, it can normalize the biases unless the implicit bias training is executed properly. Given this lack of uniformity in implicit bias trainings, Congress should recommend additional research regarding the efficacy of the Implicit Association

[39] Elizabeth Chuck, "How training doctors in implicit bias could save the lives of black mothers," *NBC News*, May 11, 2018, https://www.nbcnews.com/news/us-news/how-training-doctors-implicit-bias-could-save-lives-black-mothers-n873036

[40] Janice Gassam, "Does Unconscious Bias Training Really Work?" *Forbes*, October 29, 2018, https://www.forbes.com/sites/janicegassam/2018/10/29/does-unconscious-bias-training-really-work/#7497d0bab8a2

[41] D.R. Williams & S.A. Mohammed, "Discrimination and racial disparities in health: evidence and needed research," *Journal of behavioral medicine*, *32*(1), 20–47, doi:10.1007/s10865-008-9185-0

[42] Jesse Singal, "Psychology's Favorite Tool for Measuring Racism Isn't Up to the Job," *New York Magazine*, https://www.thecut.com/2017/01/psychologys-racism-measuring-tool-isnt-up-to-the-job.html

Test and implicit bias programs in decreasing bias, particularly in the medical community.

Overall, the components of the RMCA have the potential to decrease maternal mortality in the immediate future; however, the implementation of the pregnancy medical home and telehealth will require significant time and preparation. The implicit bias program can be implemented in a shorter time frame, but will require more time to reap the benefits of the program. Given this, it is unlikely that the bill will meet the goal of decreasing maternal health by 50 percent by 2030 and a more realistic goal should be set.

VI. Political Analysis

There are a variety of key stakeholders in the effort to address maternal mortality. The most recent policy efforts have been centralized within Congress and within state legislatures. In April of 2019, Congress adopted a Black maternal health caucus, spearheaded by two Congresswomen, with the aim of creating innovative policy to address the crisis facing Black mothers in the United States. The issue of maternal mortality has been one with bipartisan support in Congress; in 2018, the Preventing Maternal Deaths Act of 2018 passed in Congress with 192 cosponsors, including 51 Republican members. However, in state legislatures, the issue, if addressed, has become a political football. In 2017, Texas proposed legislation to create a maternal mortality task force to address the doubling maternal mortality statistics; however, the bill failed to pass because Tea Party-backed lawmakers refused to vote for any Democratic bills until their own bills progressed[43].

Many of the champions behind policies such as the RMCA or the Preventing Maternal Deaths Act are advocacy organizations, such as the Black Mamas Matter Alliance, Planned Parenthood, the Center for Reproductive Rights, and the American College of Obstetricians and Gynecologists (ACOG). ACOG was one of the first organizations to take action and collaborated with the CDC in 1986 to create the Pregnancy-Related Mortality Surveillance System. Since then, ACOG has partnered with policymaking officials at the state and federal level to establish recommended standards for maternal death statistics, identify opportunities for prevention and system

[43] CBS News, "Texas lawmakers fail to take action on skyrocketing pregnancy-related deaths," *CBS News*, June 5, 2017, https://www.cbsnews.com/news/texas-lawmakers-fail-to-address-high-maternal-mortality-pregnancy-deaths/

improvement and address rural healthcare shortages[44]. The Black Mamas Matter Alliance, established in 2013 by the Center for Reproductive Rights and SisterSong, focuses on Black maternal mortality and orchestrates regular convenings to share research, craft policy and introduce holistic approaches to care[45]. Reproductive rights organizations, such as Planned Parenthood, also provide support in this effort through grassroots mobilization and often draw parallels between the issue of maternal mortality and access to family planning and abortion services.

As maternal mortality is a global issue that has been addressed in the Millennium Development Goals and the Sustainable Development Goals developed by the United Nations, key stakeholders include multilateral organizations, such as the UN and the World Health Organization. These organizations have set goals for decreasing maternal mortality, most of which the United States has not met; however, because the United States is a major funder, it has not been criticized as much for its poor mortality rates. Because the UN and the WHO have engaged in policymaking to mitigate maternal mortality in countries across the globe and enforce international maternal mortality standards, they are key stakeholders in this issue and have a wealth of knowledge that policymakers in the United States could benefit from. If the U.S. does decrease mortality rates, it can serve as a model for other United Nations member states with low or stagnant rates.

As expected, the administrative agencies that will implement the RMCA and other maternal health initiatives are also key stakeholders. These include the Department

[44] ACOG, "Improving Maternal Health," *ACOG*, https://www.acog.org/About-ACOG/ACOG-Departments/Government-Relations-and-Outreach/Federal-and-State-Issues/Improving-Maternal-Health
[45] Black Mamas Matter Alliance, "About," *BMMA*, https://blackmamasmatter.org/about/

of Health and Human Services (DHHS) and the CDC. DHHS has already established a Maternal and Child Health Bureau which focuses on improving health outcomes for mothers, children and families through state programs, metrics for evaluation and research/training[46]. Given that the goals of the RMCA fall within this, it is likely the DHHS will be an ally in this process. The CDC, which houses the current maternal mortality tracking system, will likely also be an ally, as stringent policies on maternal health and data collection improve the reliability of nationwide information.

Though administrative agencies, members of Congress, multilateral organizations and advocacy organizations are in support of policy efforts to improve maternal health, these efforts will likely be opposed by state governments, the medical community, and the Centers for Medicare & Medicaid Services. Many state governments have been hesitant to address this issue because they do not see it is a priority or as an issue that should be addressed by physicians and hospitals. The mandate issued by the RMCA, though funded, creates a significant amount of work for state governments to bear, and states may oppose this federal government intrusion into local policies. Similarly, the medical community may oppose the RMCA, particularly the implicit bias trainings, because doing so may imply that the blame is on physicians who allow their implicit biases to manifest in poor care for patients of color. This implication could have wide-ranging impacts on physician liability and open the door for more racial bias-based medical malpractice suits. The Association of American Medical Colleges has begun providing implicit bias trainings, but adopting these trainings as commonplace may encounter resistance from the medical community.

[46] HRSA Maternal & Child Health, "About the Maternal and Child Health Bureau (MCHB)," *HRSA, January 2019,* https://mchb.hrsa.gov/about-maternal-and-child-health-bureau-mchb

The pregnancy medical home programs imposed by the RMCA will likely meet resistance by the Centers for Medicare & Medicaid, as the programs will require changes in Medicaid funds received by state recipients. The varying nature of each state's pregnancy medical home programs may also create a complex environment for Medicaid administrators to understand and navigate. Additionally, the RMCA's implementation of telehealth programs would require an expansion of current Medicaid coverage to include non-traditional healthcare delivery methods promoted by telehealth and mobile health clinics. Given that there is currently a lack of federal legislation regarding telehealth, there will also be concerns regarding uniformity of standards of care, patient privacy and payment that could serve as a barrier to Medicaid funding and support.

Nationwide public opinion polling toward maternal health policy has been limited. It is assumed that most Americans are in favor of reducing maternal mortality in the United States; however, most Americans are largely unaware of how high the current rates are. A study conducted in Texas found that only 17 percent of surveyed Texans were aware that the state maternal mortality rate has increased despite the release of a report by the state task force stating so[47]. Among those surveyed, 62 percent of women and 55 percent of men, once made aware of the issue, said that state lawmakers should make maternal mortality one of the top health priorities[48]. Of all survey participants in Texas, there was a consistently greater percentage of women who favored increased access to healthcare. For example, 43 percent of women, compared to 33 percent of men,

[47] Episcopal Health Foundation, "EHF/KFF Poll: Most Texans don't know about the recent increase in the state's maternal mortality rate," *Episcopal Health Foundation*, October 23, 2018, http://www.episcopalhealth.org/en/news/releases/ehfkff-poll-most-texans-dont-know-about-recent-increase-states-maternal-mortality-rates/

[48] Robin Fields, "Maternal deaths are increasing in Texas, but probably not as much as officials thought," *KVIA News*, January 5, 2018, https://www.kvia.com/news/texas/maternal-deaths-are-increasing-in-texas-but-probably-not-as-much-as-officials-thought/681830840

favored increased access to healthcare in rural areas. If extrapolated to the rest of the nation, this poll could indicate wide support for maternal health policies and increased access to healthcare, particularly among women in America. Because of limited polling data, it is unclear how Americans propose to address this issue or to pay for the policies. An MSNBC poll found that 50 percent of individuals surveyed believe that the cost of maternal/newborn health should be spread across all insurance policies while 41 percent of individuals surveyed believe it should be the sole responsibility of individuals having kids[49]. This indicates a sharp divide between individuals who believe the onus of maternal health is on the general public and the government versus those who believe it is on individual families.

Though there is a lack of polling on maternal health, there is significant polling on one aspect of the RMCA- telehealth. 77 percent of Americans surveyed have expressed willingness to conduct a virtual healthcare encounter.[50] Of this group, 21 percent expressed concerns over care quality and technological failures when using telehealth services. These concerns have not, however, prevented patients from using telehealth services when offered; 22 percent of patients have reported already having a telehealth encounter[51].

Given the opinions of the aforementioned stakeholders, it is likely that any maternal mortality legislation would have overwhelming Congressional and grassroots

[49] MSNBC, "Poll: Who is responsible for maternal health care," *MSNBC*, http://www.msnbc.com/msnbc/poll-who-responsible-maternal-health-care
[50] Sara Heath, "77% of patients want access to virtual care, telehealth," *Patient Engagement HIT*, June 20, 2017, https://patientengagementhit.com/news/77-of-patients-want-access-to-virtual-care-telehealth
[51] Jennifer Bresnick, "Strong patient demand for telehealth motivated by convenience," *Patient Engagement HIT*, October 3, 2016, https://mhealthintelligence.com/news/strong-patient-demand-for-telehealth-motivated-by-convenience

support. Even with resistance from Medicaid and state governments, it is likely that the RMCA will survive the legislative process. Still, it is imperative that sponsors of this legislation, such as yourself, mitigate the political costs of the bill and control the conversation surrounding it. One effective way to raise support for the RMCA is by focusing on the stories and testimonies of women and families affected by maternal mortality, including celebrities like Serena Williams. By focusing on the stories of women and families affected by maternal mortality across the United States, co-sponsors can shame legislators who do not support the bill for neglecting their constituencies and emphasize the urgency of the issue. Because maternal mortality is deeply tied to the issue of access to healthcare, the policy solutions proposed by the RMCA can also be applied to other public health crises. The implementation of telehealth services through the RMCA can provide a framework by which lawmakers in states can address other public health crises within underserved communities, such as the opioid epidemic. In a survey of rural Americans, 23 percent cited drug addiction or abuse as the most urgent health problem in their communities[52]. By appealing to a variety of public health issues, co-sponsors can obtain the support of legislators and administrative agencies that may be hesitant to support the RMCA.

Finally, a key component of passing the RMCA is controlling the conversation surrounding maternal health. It is commonly known, domestically and globally, that maternal health outcomes can be improved by increasing access to contraceptives and abortions to decrease the rate of unwanted pregnancies. However, given the controversial nature of both subjects in Congress and within the current Presidential administration,

[52] NPR, Life in Rural America, *National Public Radio*, October 2018, https://www.npr.org/buckets/HARVARD-POLL/rural-health-poll-10-15-18-updated.pdf

any mention of family planning or abortion will result in the failure of the bill. Organizations, such as Planned Parenthood, may attempt to invoke this argument and point out the hypocrisy of states like Texas decreasing the number of abortion clinics in the state while simultaneously attempting to address maternal health. It is vital that Congressional efforts regarding the RMCA avoid coordinated efforts with organization advocating for abortion or contraceptive access, as that will add controversy to the bill. The issue of access to abortion and contraceptives is critical but will require a much heavier political lift, particularly in this political climate.

VII. Recommendation

It is recommended that Congresswoman Holmes Norton strongly support the RMCA and co-sponsor the legislation. Despite the aforementioned weaknesses of the policy proposal, the RMCA contains innovative and cost-efficient methods of decreasing maternal mortality across the United States. Opponents have concerns regarding the cost of this program, but the program's $73,000,000 budget has the potential to decrease the estimated $1 billion spent annually on costs associated with maternal mortality. By preventing maternal deaths, the United States can continue to increase economic productivity, particularly among women and families, and increase trust in the maternal healthcare system. As maternal mortality rates increase, women may seek alternative forms of maternal care or may become hesitant to become pregnant altogether, both of which would cause financial harm to hospitals.

Critics of the RMCA also state that it does not address all factors that cause maternal mortality, some of which include obesity, diet, lack of health insurance coverage, decreased access to abortion services and availability of contraception. However, the United States has let perfection become the enemy of the good in this instance for far too long. The RMCA is one of the first comprehensive pieces of legislation introduced on this issue in decades and will likely not be the last. Efforts to enact universal healthcare or increase access to family planning and abortion are vital but also controversial and time-consuming; the United States must start somewhere.

By passing the RMCA, the United States can also increase its global credibility. As a major funder of maternal health initiatives across the globe, it is hypocritical for the United States to ignore its domestic maternal health issues. With the RMCA, the United

States has the potential to become a model for global counterparts and prompt increased attention to maternal health.

The RMCA has the potential to become a landmark piece of legislation in the field of maternal health. It is widely documented that women, particularly women of color and women of lower socioeconomic status, are most at risk for maternal death; however, maternal health policies often do not address the daily realities faced by these women. The RMCA utilizes innovative approaches to address the multitude of factors that impact women at the intersection of their identities. As stated by Audre Lorde, an American feminist and writer, "there is no such thing as a single-issue struggle, because we do not live single-issue lives.[53]" Through the RMCA's efforts, a Black, low-income woman living in a rural environment can have increased access to equitable, accessible and non-judgmental maternal care in her state. By centering the issues of the most marginalized mothers, the U.S. can ensure that everyone receives the maternal healthcare and access that they deserve.

As representative of the District of Columbia, Congresswoman Holmes Norton has seen firsthand the harm caused by decreased access to maternal healthcare and the disproportionate impact on minority communities. In the District, telehealth services and pregnancy medical home programs can increase the accessibility of maternal healthcare in light of the closing of labor and delivery units across the city. The RMCA will address this public health crisis, not just for D.C. residents but for women across the country who deserve better.

[53] Audre Lorde, "Learning from the 60s," *Sister Outsider: Essays & Speeches by Audre Lorde*.

As the United States begins to adopt more progressive, feminist policies on issues such as equal pay or sexual harassment, the issue of maternal health has been at a standstill. The United States must take action by passing the RMCA, a bill that is evidence-based, bipartisan and intersectional. Women in America cannot wait.

Curriculum Vitae

Lienna Feleke-Eshete was born on November 15, 1994 in Buffalo, New York and raised in Laurel, Maryland. In high school, she was a Gifted & Talented and AP student and was accepted into the prestigious Gemstone Program in the University of Maryland Honors College. At university, Lienna studied Government & Politics with a minor in French and coursework in Arabic studies. Through Gemstone Lienna conducted a three year group research project on the effects of pH manipulation on tumor proliferation and the ability of T cells to kill cancer cells or stop metastasis. Outside of the classroom, she was involved in campus organizations such as the Half the Sky Planning Committee and the Ethiopian-Eritrean Student Association, and interned at a variety of organizations including, The White House, The Borgen Project and the American Association of University Women. After graduating from the University of Maryland, Lienna pursued a career in public service as a Staff Assistant and, later, a Caseworker in the office of U.S. Senator Ben Cardin. Since then, Lienna has continued her passion for public service and activism throughout her career as an employee at Planned Parenthood of Metropolitan Washington, D.C. and currently at the Center for Health and Gender Equity (CHANGE). As an advocate, Lienna strives to bridge the gap between historically disenfranchised groups- particularly women, girls, immigrants and people of color- and policymakers and appropriately incorporate these groups in the policymaking process in a culturally competent and intersectional manner.

Lienna Feleke-Eshete

lienna.felekeeshete@gmail.com, LinkedIn

EXPERIENCE

The Center for Health and Gender Equity (CHANGE) Washington, D.C.
Public Policy Associate March 2019- Present

- Conduct analysis of legislation and policies related to U.S. global health assistance for HIV and AIDS, family planning and reproductive health, sex work and anti-trafficking initiatives, abortion, LGBTQ health and rights, gender-based violence and multilateral institutions.
- Provide educational and technical assistance to Members of Congress and other key policymakers.
- Attend regular coalition meetings on behalf of the organization.
- Assist the Communications Department with issuing public statements and policy briefs for a variety of audiences and manage the organization's Rapid Response action alerts.
- Coordinate an Intern Summer Series on reproductive justice and global health for 40-70 interns.
- Supervise policy interns.

Planned Parenthood of Metropolitan Washington, D.C. Washington, D.C.
Public Affairs Coordinator June 2018- March 2019

- Coordinated and managed public policy, advocacy and community organizing efforts for Planned Parenthood of Metropolitan Washington (PPMW) and Planned Parenthood of Maryland (PPM) in DC, Northern Virginia and Maryland to protect and expand access to reproductive healthcare in the DMV area.
- Drafted and implemented compliance protocols and internal procedures for staff and stakeholders for PPMW and PPM's newly formed 501(c)(4) organization, Planned Parenthood Advocates for DC, Maryland & NoVa (PPADMV), according to Planned Parenthood, Internal Revenue Service and state-specific campaign finance guidelines.
- Managed PPADMV's board of directors and three jurisdiction-specific advocacy committees
- Created and maintained relationships with elected officials and other coalition organizations to create effective, strategic and inclusive campaigns on the local, state and federal levels.
- Planned and organized fundraising opportunities for PPADMV and PPADMV's political action committees.
- Supervise public affairs department interns.

United States Senate, The Office of Senator Benjamin Cardin Baltimore, MD
Caseworker (February 2017 - May 2018) June 2016- May 2018

- Served as the liaison between over 500 Maryland constituents and local, state and federal agencies, including but not limited to the Department of Homeland Security, the Department of Justice, the Equal Employment Opportunity Commission, the Small Business Administration and Emergency Relief Services.
- Assisted constituents with expediting passport applications for travel within 48 hours.
- Designed graphics, brands and signage on Adobe Photoshop for Senator Cardin's events, website and social media.
- Trained Staff Assistants and interns in Senator Cardin's Baltimore office.

Staff Assistant (June 2016 - February 2017)

- Directed approximately 9,000 constituent concerns to appropriate caseworkers, agencies or legislators via mail, email, phone and Intranet Quorum.
- Managed and update the daily calendar for the Senator and for field representatives.
- Prepared and distributed newsletters regarding Senator Cardin's events and recent legislation.
- Supervised interviews and compiled applications for Service Academy nominations from Senator Cardin via the OAM webpage.

White House Internship Program Washington, D.C.
Scheduling & Advance Department Intern May 2014- August 2014

- Responded to constituent invitations and gifts addressed to the First Family via Salesforce, Outlook and hard copy mail.
- Traveled with the President to Kansas City, Missouri as a member of the Advance team and led a team of staff in organizing the arrival and departure of Air Force One.

American Association of University Women Washington, D.C.
STEM Education Programs Intern September 2015-May 2016

- Organized logistics and presentation materials for STEM training camps created to peak young women's interests in STEM fields.
- Managed AAUW STEM social media accounts and contributed to the organization's online content.
- Converted over 1,000 evaluations from STEM camps to an evaluable format on Certain.

McCollum & Associates, LLC College Park, MD
Legal Intern June 2010- January 2016

- Interviewed prospective clients about their legal needs and briefed attorneys regarding clients' cases.
- Conducted research on legal databases, such as Westlaw and LexisNexis, to find case law.
- Prepared legal documents, including interrogatories, business contracts, will and testaments, and discovery requests.

The Borgen Project Remote
Blogger October 2013- January 2014

- Composed over thirty articles for the Borgen Project blog and magazine on topics such as industrial transparency, advances in prenatal technology, and African politics.
- Raised over $200 in donations to aid The Borgen Project's efforts.

EDUCATION

Johns Hopkins University Washington, D.C.
Candidate, Master of Arts in Public Management August 2017-August 2019

University of Maryland, College Park College Park, MD
Bachelor of Arts in Government & Politics August 2012-May 2016
Minor in French Studies, Coursework in Arabic Studies

The Paris Institute of Political Studies (Sciences Po) at Menton Menton, France
August 2014-December 2014

SKILLS

- Advanced experience with Windows and Mac Operating Systems, Microsoft Office and Adobe Photoshop
- Proficient with Internet Quorum, VAN, EveryAction, Lexis Nexis, Congressional Research Service, Westlaw, Salesforce
- Languages: English (native speaker), French (limited working proficiency), Arabic (Basic) and Amharic (native speaker)